1. State Assistance Request #

Form 500A

COUNTY INDIGENT HEALTH CARE PROGRAM
REQUEST FOR STATE ASSISTANCE FUNDS

2. County Name: _____

3. Payment Address: _____

_____

_____

4. County Vendor ID #: _____
(For Payment Address)

5. 100% of County Spending for this Request: $ _____

6. Date Paid: _____

7. Amount Requested (100% of County Spending) $ _____

This is a request for reimbursement from the State Assistance Fund for health care services provided under the County Indigent Health Care Program (Chapter 61, Health and Safety Code,) and paid by the end of August 31, 2016. The payee agrees to repay any funds paid in error and acknowledges the state's authority to collect any funds paid in error.

_____ _____
County Judge / Designee Date

_____
Printed Name of County Judge / Designee

( ) _____
Telephone Number

March 2017

PURPOSE

Use to notify the Health and Human Services Commission (HHSC) that the county is requesting state assistance funds for health care assistance reimbursement provided under the County Indigent Health Care Program.

PROCEDURE

Contact HHSC by telephone to request state assistance funds before the Commissioners Court authorizes payment of the health care claims.

Complete and submit Form 500A to the County Indigent Health Care Group in Austin to claim state assistance funds within 30 days from the request for state funds.

File a copy of the Form 500A for county records.

DETAILED INSTRUCTIONS

1. Enter the approval number that was assigned to your request by HHSC.

2. Enter the name of the county.

3. List the address where the county receives payments for services, including the zip code.

4. Enter the county's vendor identification number for the address in item 3.

5. Enter the amount of money for which the county is requesting reimbursement.

6. List the month and year in which the county paid the money listed in #5.

7. Enter 100 percent of the eligible program costs, i. e., 100% of the amount listed in #5.

The County Judge or his designee must sign and date the Form 500A. The form and supporting documentation of expenditures may be faxed to HHSC at 512-776-7203 or mailed to:

Health and Human Services Commission
County Indigent Health Care Group MC 2831
P.O. Box 149347
Austin, Texas 78714-9347

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year.